

1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3561
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 703

(b) Township Stinson Primary Registration District No. 4424 Registered No. _____

(c) City Humansville (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Minnie Lucas Yeager

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. B. Yeager

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 4

7. AGE YEARS 67 MONTHS 3 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper

9. Industry or business in which work was done, as saw mill, bank, etc. House work

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1, 1939

22. I HEREBY CERTIFY That I attended deceased from Dec 31, 1938, to Jan 1, 1939. I last saw her alive on Jan 1, 1939. Death is said to have occurred on the date stated above, at 9:05 p.m.. The principal cause of death and related causes of importance were as follows:

Severe Expiratory dysnea
Respiratory (Paralysis)

Date of onset 30 day

Other contributory causes of importance: she had a cancer of breast taken off about 2 yrs ago.

Name of operation none Date of _____

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____. Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no If so, specify _____ (Signed) R. Q. Neuman, M. D. (Address) Humansville, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton, Mo.

FATHER

13. NAME Wanda

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. Marvin Hoffman, 2300 E. Main, Humansville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Humansville DATE Jan 3, 1939

19. FUNERAL DIRECTOR (ADDRESS) White Services, Salinas, Mo.

20. FILED Jan. 4, 1939 Ora M. Rich Local Registrar.

WHILE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 71

District File Number 7-39-95-

Date Filed 1-12-99

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)